Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Narcotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Information about the MassHealth Drug List can be found at **www.mass.gov/masshealth**. Please refer to the Therapeutic Class Tables and Pain Initiative for specific information regarding prior authorization requirements for narcotics.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

PA is required for:
-oxycodone controlled-release (OxyContin):
-fentanyl transdermal (Duragesic)
*Members will be exempt from PA if a pharmacy received a paid claim for these drugs for the member within the past 90 days and are filling no more than 30 patches/month or 200mcg/hr of fentanyl transdermal (Duragesic) or 90 tablets/month of oxycodone controlled-release (OxyContin).

PA is required for the following doses:
-oxycodone controlled-release (OxyContin) > 240 mg/day
-fentanyl transdermal (Duragesic) > 200mcg/hr
-levorphanol > 32mg/day
-methadone > 120 mg/day
-morphine controlled-release (MS Contin, Oramorph SR, generics) > 360 mg/day
-morphine sustained-release (Kadian) > 360 mg/day
-codeine > 360mg/day
-hydromorphone > 60 mg/day
-meperidine > 750mg/day
-morphine immediate-release > 360mg/day
-oxycodone immediate-release > 240 mg/day

PA is required for the following quantities:
-oxycodone controlled-release (OxyContin) > 90 tabs/mo.
-fentanyl transdermal (Duragesic) > 30 patches/mo.

Other narcotics may also require PA.

Drug Name (Requested)

Dose and frequency of requested drug

Expected duration of therapy
☐ < 6 months ☐ ≥ 6 months

Indication
☐ Cancer pain (specify type and stage):_____
_____
☐ AIDS:_____
☐ Other (specify):_____
_____

-If request is for oxycodone controlled-release or fentanyl transdermal, please complete section I (and section II if applicable).

-If request is for narcotic that exceeds dose/quantity limit, please complete section II (and section I if applicable).

Section I

Please complete for oxycodone controlled-release or fentanyl transdermal requests.
Has member tried sustained-release or controlled-release morphine?

Yes. Please complete box at the top of page 2.
No. Please explain why not.

_____
_____

(cont.)

Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Details of adverse reaction, inadequate response, or other:

Medication information

Section II

Please complete for dose/quanitity limit requests.

Is the member under the care of a pain specialist? ☐ Yes ☐ No

Name of specialist: _____ Phone no.: (___) _____

Date of last visit or consult with pain specialist: _____
Please attach copy of pain consult note if available.

What is the complete pain-management regimen, including other pain medications, adjunctive therapy, and/or controlled substances? Please include the names and doses of these medications. _____

Has the member had a psychological evaluation? ☐ Yes ☐ No

Does the member:
have a history of substance abuse or dependence? ☐ Yes ☐ No
have a history of alcohol abuse or dependence? ☐ Yes ☐ No

Does the member have a treatment agreement (e.g., lock-in pharmacy and prescriber, early refill policy, consequences of nonadherence to treatment)?

☐ Yes (Attach copies.) ☐ No (Explain why not.)

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date